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ABSTRACT

Although family child care has the potential to offer young children individual attention and customized, educational programs to help them thrive, the quality of these programs is dependent upon a workforce that is at the bottom of the occupational status and pay hierarchy. This report examines ways to promote high quality in family child care programs. Part 1, "Family Child Care Today," considers the demographics of family child care, its strengths and liabilities, and the role of education. Part 2, "Strategies for Supporting Quality in Family Child Care," examines characteristics of appropriate training and incentives for training family child care providers; ways to ensure small group size and low adult-child ratio; family child care regulations; methods of ensuring continuing professional development among providers; and infrastructure support such as provider associations, resource and referral agencies, and food programs. Part 3, "Barriers That Inhibit Quality in Family Child Care," addresses low compensation, low social status and cultural devaluation, low job retention of providers, family child care costs, inadequate financing, and the absence of a national alliance for early care and education. Part 4, "A Vision of Support for the Quality of Family Child Care," examines the coordination of effort at the national and community level necessary to secure comprehensive support for the quality of family child care, including a major shift in public opinion, federal legislation, foundation and corporation funding, community provider support, parent support, and improvement of compensation for providers. (Contains 92 references.) (Author/KB)

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PROMOTING HIGH-QUALITY FAMILY CHILD CARE

A Policy Perspective for Quality 2000

by

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January, 1994

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TABLE OF CONTENTS

PROMOTING HIGH-QUALITY FAMILY CHILD CARE

Part 1. Family Child Care Today 1
A. The Demographics of Family Child Care 1
B. The Quality of Family Child Care 3
1. The Special Strengths and Liabilities of Family Child Care 4
2. The Role of Education in Family Child Care 5

Part 2. Strategies for Supporting Quality in Family Child Care 6
A. Training 7
1. The Current Situation in Training 7
2. Characteristics of Appropriate Training 9
3. Incentives for Training 10
B. Ensuring Small Group Size and Low Adult-Child Ratio 11
C. Regulation 12
1. The Current Situation 12
a. State Approaches to Regulation 12
b. Unregulated Family Child Care 13
2. Issues in Regulation 14
a. The Level of Standards 14
b. Monitoring and Enforcement 16
c. Isolation and the "Underground" 16
D. Continuing Professional Development 17
E. Infrastructure Support 19
1. Provider Associations 19
2. Resource and Referral Agencies 20
3. Licensing Agencies 20
4. Food Programs 20
5. Systems 20

Part 3. Barriers That Inhibit Quality in Family Child Care 21
A. Low Compensation 21
1. Income 21
2. Fringe Benefits 22
3. Income Taxes 23
B. Low Social Status and Cultural Devaluation 24
C. Low Job Retention of Providers 25
D. The Cost of Family Child Care 25
1. Current Market Cost 26
2. The Full Cost of Care 26
3. Market Failure 26
4. Lack of Awareness and Organization Among Providers 27
5. The Affordability of Family Child Care for Parents 27
E. The Inadequate Financing of Family Child Care 29
1. The Lack of Government Support 30
2. The Lack of Corporate Support 31
F. The Absence of a National Alliance for Early Care and Education 32

Part 4. A Vision of Support for the Quality of Family Child Care 34
A. The National Level 34
B. The Community Level 36

Endnotes 38

Bibliography 43

PROMOTING HIGH-QUALITY FAMILY CHILD CARE

Family child care, also known as family day care[1], is offered in the provider's home for children from infancy through the school age years. Providers care for and educate non-resident children, who usually live nearby. Many providers have young children of their own as well. Typically, state regulations limit family child care providers to approximately six children, though seven states do not regulate family child care in any way. Thirty-nine states also regulate large/group family child care, limiting a provider with an assistant to twelve or more children (see the section on regulation.) The average group size across all regulated and unregulated homes is three to four children (Hofferth & Kisker, 1992).

Family child care is a new field of study. Though it is also surely one of the oldest occupations, it has been nearly invisible, woven into the fabric of every neighborhood. There exists no comprehensive, scientific research base to inform public policy and program planning in the field. Funding for child care program development and research has usually been directed at center-based programs. This paper integrates findings from existing research about family child care with the experience of providers and support agency staff members.

The paper also addresses the quality of family child care and strategies to support such quality. Part 1 serves as an introduction to family child care today. Part 2 describes strategies for supporting quality in family child care. Part 3 discusses barriers that inhibit the quality of care. And Part 4 posits a vision for the future of family child care support at the national and community levels.

PART 1. FAMILY CHILD CARE TODAY

This section analyzes the state of family child care today. It reviews demographic statistics, the strengths and liabilities of family child care, and the role of education in this form of care.

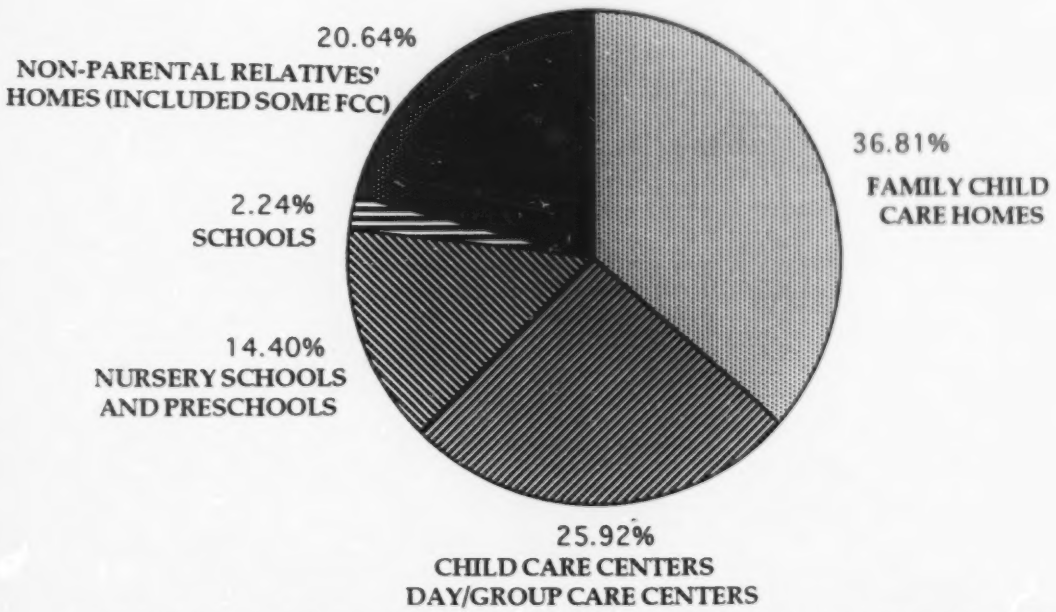
The Demographics of Family Child Care

Approximately 4,000,000 children in the United Sates are cared for by about 1,000,000 providers in family child care, according to combined data from the Profile of Child Care Settings Study and the National Child Care Survey 1990 (Willer, Hofferth, Kisker, Divine-Hawkins, Farquhar, & Glantz, 1991). Nearly half of all child care outside the child's home occurs in family child care, according to the

Census Bureau (O'Connell & Bachu, 1992). Figure 1 shows the percentages of children under age five in each of the following child care settings:

- family child care homes (37%)
- child care centers (26%)
- non-parental relatives' homes, some of which are family child care homes (21%)
- nursery schools and preschools (14%)
- schools (2%)

FIGURE 1. PERCENTAGE OF CHILDREN UNDER AGE 5 IN CHILD CARE SETTINGS OUT OF THEIR OWN HOMES



Calculated from 1988 Census data (O'Connell & Bachu, 1992) for children of working mothers, eliminating arrangements where the father cared for the child, or the mother did so while working, or the care occurred in the child's home (by a "nanny" or "babysitter").

Because some of the non-parental relatives in this chart include grandmothers, aunts, and other relatives who take care of unrelated children as well as relatives, some of the children in relative homes should be included in the family child care statistics. Unfortunately, we have no way even to estimate these numbers.

Parents choose family child care more often than any other form of care for infants and toddlers, while they choose it less often for older children (O'Connell &

Bachu, 1992). They usually rely on friends and neighbors as sources of information about child care (Kontos, 1992).

Providers vary widely in age with a slight tendency for white providers to be younger and to care for their own young children in addition to unrelated children, while black providers tend to be somewhat older and have older children (Hofferth & Kisker, 1992). Fully 80% percent of providers are married (Kontos, 1992), perhaps because of the need for financial support and fringe benefits from another source.

According to Hofferth & Kisker (1992), about half of all providers have graduated from high school and taken some college-level courses; but only 11% of regulated and 15% of unregulated providers have completed college or graduate programs. Almost two-thirds of regulated providers in the Hofferth and Kisker study have had some child-care-related training. Other studies have found average levels of provider education ranging from a high school diploma or less to two years of college (Kontos, 1992). While many providers believe that their parenting experience is the only training they need, Nelson (1990) observed that by equating their skills with mothering, they often denigrate their own considerable knowledge — an internalization of our cultural devaluation of traditional women's work. Providers who take appropriate training courses (sometimes reluctantly, in order to meet licensing requirements) usually report that training helps them do a better job and recommend training to their friends (Dombro & Modigliani, 1993).

The Quality of Family Child Care

Our knowledge base about the quality of family child care is limited.[2] Existing studies have usually been hindered by small and unrepresentative samples. Compounding the problem, most family child care providers are not regulated, do not appear on any list, and thus are difficult for researchers to identify. The characteristics of unregulated care are particularly unknown, although the National Child Care Survey suggests that unregulated programs may be more similar to regulated care than previously believed (Hofferth & Kisker, 1992). Reflecting the limited research base and the isolation of providers, we have no well-defined consensus within the field concerning the characteristics of high-quality family child care.[3] We have no recognized models of quality; providers, parents, trainers, and policy makers lack concrete examples of the look and feel of excellence in this type of care. Research findings about the quality of family child care are often inconsistent, so only a few conclusions can be drawn.

The Special Strengths and Liabilities of Family Child Care

Family child care is unique. Its profound differences from center-based care elude researchers and program specialists who often simply transpose their more highly developed understanding of center-based care to the home setting. The inherent nature of family child care is the source of its greatest strengths in supporting the quality of early care and education as well as the source of its greatest challenges.

Perhaps its greatest asset is that a single caregiver is responsible for only a few children (or, in the less common case of a large/group family child care home, two caregivers are responsible for a still relatively small group of children). The quality of the relationships between the provider and each child tend to be more intimate in family child care than in center care, because there are fewer children to relate to and because some of them stay with one provider for several years. Providers are especially able to customize activities to meet the needs of individual children: to get to know the nuances of a baby's needs, to listen carefully to what children say, to carry on relaxed, extended conversations, and generally to "be there" for each child. This characteristic makes family child care particularly appropriate for very young children and for those who are better off in an intimate setting for various reasons.

Closely related is the relaxed, informal nature of most family child care programs. There is no need for rigid schedules because the provider does not have to coordinate her work with a team of teachers. A soft, homey atmosphere may be just the thing for a school-ager after a long day in school, as well as for young children who are not ready for more complex, structured institutions.

Another special characteristic of high-quality child care homes is that the enrolled families can be a central focus. Providers can have close relationships with parents and all the families combined can become like an extended family, socializing together and supporting each other outside the child care setting. Finally, the mixed-age groups that occur naturally in family child care (and rarely in centers) offer opportunities for children to learn from other children and to teach and care for others.

The related liability of this type of care is that the decentralized nature makes it difficult to enforce regulations or deliver training, supervision, and other support services. Most providers function in isolation without any such support. Furthermore, because many providers tend to define their role as second mother rather than teacher, they may not recognize the value of professional support or feel responsible for educating the children in their care. Because of the homey setting,

many providers are reluctant to see their service as a business and fail to charge what they need to cover their costs (see The Full Cost of Care, below). One effective solution to the problems of decentralization is the family child care system or satellite agency, which deliver comprehensive services to designated groups of providers (Cohen, 1992; Larner & Chaudry, 1993; Ward, 1991). Professional development among providers — expanding in response to newly available training and other supports — is evolving other solutions to problems caused by decentralization.

Many providers and support staff believe that we have not fully identified the special characteristics of family child care quality — another manifestation of the undeveloped nature of the field. Indeed, the research instruments most commonly used for assessing family child care quality were derived from center-based approaches (for example, the Family Day Care Rating Scale by Harms and Clifford, 1988; and the National Association of Family Child Care's Accreditation Assessment Profile by Sibley and Abbott-Shim, 1992). Are some aspects of quality in home-based programs overlooked? Current assessment instruments recognize the quality of providers who resemble preschool teachers; they tend to under-rate providers who resemble good parents and facilitate learning activities around the routines of daily living (Modigliani, 1990). For example, is there a sense of family belongingness[4] that is supported in good child care homes, and if so, should not this factor be added to the list of quality criteria? Perhaps when we identify special aspects of quality in family child care, we will find attributes we want to include in the criteria for assessing center-based quality as well.

The Role of Education in Family Child Care

The field of early care and education has come to the consensus that high-quality education for young children is facilitated by what is called "developmentally appropriate practice." Described in detail for child care centers and schools in *Developmentally Appropriate Practice* (Bredekamp, 1987), this approach applies just as well to family child care. Essentially, it suggests that providers should prepare an environment in which children can explore and learn through active play and interaction with the provider, the other children, and the materials. Instead of isolated lessons directed by the provider, activities should be "hands on" and meaningful in the context of the child's daily experience. Providers should extend and facilitate play in response to what they have observed of individual children's needs and interests. Home-based care can be an ideal setting

for developmentally appropriate early childhood education, but most providers, like center teachers, need appropriate training to learn how to carry out this type of program and curriculum (see Training, below).

Parents and early childhood professionals alike often fail to recognize the potential of family child care to educate children. When a provider carries out developmentally appropriate practice, the program can be optimally educational, though it may look different from a good center program. Improvement in the quality of care and education in family child care settings will depend in part upon the elaboration of an informal type of developmentally appropriate curriculum as well as increased societal respect for the critical learning that occurs in very young children in homey environments.

PART II. STRATEGIES FOR SUPPORTING QUALITY IN FAMILY CHILD CARE

A variety of strategies have been effective in supporting the quality of early care and education in child care homes. Public and private efforts include sponsorship of training, small group size and staff ratio, and compliance with regulation. These three factors are associated with quality in center-based research findings and are assumed to function similarly in home-based care. Child care regulators as well as researchers have tended to focus on *indicators* of quality — that is to say, easy-to-assess variables that have been found to be correlated with quality — rather than the nuanced behavior that directly promotes quality: While these factors do not *ensure* quality, they are associated with it and signal conditions that promote it.

Efforts to improve the income and benefits of providers have been sponsored in a few states and communities (see the publications and newsletters of the National Center for the Early Childhood Work Force).

Several other strategies appear to be effective in enhancing the quality of family child care as described above, including newsletters; consumer education; accreditation initiatives; advocacy initiatives; resource rooms and lending libraries; toy, equipment, and home improvement grants; technical assistance (e.g. warm lines; insurance pools and bulk purchasing); and substitute services.

Such a multiplicity of strategies requires an effective infrastructure to coordinate funding streams and service delivery. At this time in history, most

communities are limited in their infrastructure to deliver family child care services. Existing models are isolated, grant-funded, and time-limited (Cohen, 1992).

Training

The benefit of child-related training in improving the quality of care is probably the most conclusive research finding in family child care (Kontos, 1992; Clarke-Stewart, 1987). The effect of the number of years of education is less clear — there appears to be some relationship between providers' education and quality of care, but the causality is not clear. It is plausible that people who have the means to complete more education also have the means to offer higher quality. Because training has been identified as the most important predictor of quality child care, this section describes the current situation in training, characteristics of appropriate training, and incentives for training.

The Current Situation in Training

A comprehensive new study by the Center for Career Development in Early Care and Education at Wheelock College (Morgan, Azer, Costley, Genser, Goodman, Lombardi, & McGimsey, 1993) gives an overview of the current training picture for family child care providers:

- Many communities offer no training of any kind specifically designed for family child care providers.
- Existing family child care training across the United States tends to be not-for-credit, entry-level, and repetitive.
- Of the 19 states requiring ongoing training for providers, a median of six "clock" hours per year is mandated. Of the 39 states regulating large/group homes, 23 require ongoing training.
- No pre-service training is required for small-home providers in 29 states; the remaining 22 states require up to 12 credit hours of pre-service training. Only 9 of the 39 states regulating large/group homes require pre-service training. (No state required any pre-service work experience.)
- The minimal or nonexistent requirements for training or education make family child care an accessible occupation for those who have experienced economic, cultural, or racial barriers to college education.
- Funds to support training appear to be extremely limited, sporadic, and largely uncoordinated. Providers and trainers subsidize the true cost of training.

- Providers have few incentives to invest in training.

Evaluation of family child care training programs in 32 U. S. communities, sponsored by the Family-to-Family Initiative of Mervyn's, Target Stores, Marshall Field's, and the Dayton Hudson Foundation, suggests additional findings (Dombro & Modigliani, 1993).

- Many providers and parents alike believe that people (i.e., women) need no special training to take care of young children, yet when providers obtain appropriate training, they report wishing they had received it earlier.

- Participating in appropriate training seems to stimulate providers' appetites for more training — the hardest step is to get them to take their first course. A demand for appropriate advanced training is created among providers who complete a good basic training course.

In their one to five years of offering training, Family-to-Family projects have attracted an average of more than 200 providers per year per community to training courses ranging from 15 to 30 hours in length. An average of 23% of all licensed providers in these communities have completed Family-to-Family training (Cohen & Modigliani, 1992; Dombro & Modigliani, 1993). The previous belief that most providers are not interested in training has been replaced by an understanding that many will be interested when appropriate training is offered. Now the trend in Family-to-Family and other provider-friendly training projects is to refine our understanding the components of appropriate and effective training for this unique occupation.

As will be seen in the section on regulation, there is a trend for states to require training as part of licensing. Unfortunately, the new requirements do not usually address the *quality* of training, so providers may be confronted with a confusing array of training of dubious and unpredictable quality. At the same time, we have learned that the most effective trainers are themselves providers or recent providers. Many providers are distrusting of so-called "experts" who have no direct experience in this setting, and often rightly so (Occasionally agencies can find trainers who are providers *and* have Master's degrees in early childhood education or child development. More often it has proved effective for two individuals with different qualifications to teach as a team.)

Other gaps in the content of existing training topics, of particular interest and importance to providers, include:

- working with infants and toddlers, school-agers, mixed-age groups, and children with special needs
- management training (IRS, contracts and policies, setting and raising fees).
- cultural, ethnic, and bilingual issues
- family support

Characteristics of Appropriate Training

Until recently, early childhood courses at the college or community level have been open to providers, but the instructors were seldom familiar with home-based care. Existing child care training tends to ignore the special knowledge needed for working effectively with mixed-aged groups. Information on setting up learning environments and planning activity schedules is often too formal and institutional for most providers' tastes as well as children's needs. Family child care providers in these classes, already feeling lower in social status than center teachers, have often concluded that such courses do not apply to their work.

Ideally, beginning-level courses should be customized for family child care by trainers whose qualifications include experience in this form of care and respect for adult learning styles.[5] After providers have gained a sense of themselves as professionals who do critically important work, they benefit from taking classes with other early childhood professionals (Dombro and Modigliani, 1993).

Appropriate training helps providers construct their own meaning from what they have learned. Hands-on activities and practice assignments seem to be more effective at promoting real learning than traditional lectures and reading assignments (Modigliani, 1993b).

In some communities, substantial proportions of providers speak languages other than English. Appropriate training is seldom available for them, although Spanish-language family child care curricula and training are now available in a few communities, especially in California and Texas (see Lawrence, Brown, Lincroft, Williams, & Bellm [1992] for an annotated list of Spanish-language materials). An effective solution to the challenge of multiple language groups is to offer a train-the-trainer course to bilingual trainers who can then teach in their native languages (Cohen & Modigliani, 1992), especially when high-quality materials and curricula are lacking in most languages.

Researchers have not yet differentiated the characteristics of training that

result in improved quality of care and education offered by providers, although the Families and Work Institute will publish findings in this area within the next year. Basic and systematic examination of the effects of various training approaches and content is sorely needed to inform public policy pertaining to training. The forthcoming findings of the Families and Work Institute's study will address the effects of training on quality in family child care.

Incentives for Training

There is little incentive for providers to seek training, other than their personal gratification. In other occupations, workers who obtain training qualify for jobs that bring increased responsibility and higher pay. In family child care, even more than center-based care, there is virtually no career ladder and no increased compensation for training.

To counteract the lack of incentives for training, two states, Minnesota and Wisconsin, have developed strategies to pay higher reimbursement rates to family child care providers with academic preparation, CDAs[6], or accreditation[7]. But the "parent choice" restriction on the Child Care and Development Block Grant (CCDBG) funding has been interpreted by most states as forbidding this attractive approach.

As seen in the section on market failure, below, parents do not usually value training for caregivers of babies and toddlers. They tend to seek providers to be surrogates for themselves, and may be suspicious that training will make providers too business-like or school-like rather than warm and nurturing. To the contrary, research suggests that teachers of very young children are most in need of training (Whitebook, Howes, & Phillips, 1989). Furthermore, even when providers gain a lot of training, parents frequently refer to them as babysitters — reflecting society's lack of appreciation for early care and education. There is no "demand-side" pressure for providers to attend training.

Finally, three pragmatic problems function as additional disincentives to training:

- Many providers cannot afford the full tuition for credit-earning training, even in public two-year colleges, and relevant courses are seldom subsidized.
- It is hard for providers to find the time and energy to go to classes, because most work 11-12 hours per day and spend some weekend hours on child-care-related activities.

- Even though providers may accumulate a great deal of non-credit training, there is little recognition for such training.

As advocated by Morgan and colleagues (1993), a few states have begun to develop registries to approve training and maintain transcripts for providers. The state of Delaware is developing an exemplary model, specifying core competencies and computerizing provider records. Experienced providers will be "grandmothered" into this system; new providers will have increased training requirements. Other policy supports for training include financial aid in the form of CCDBG training funds (often used by states to fund disproportionate amounts of center-based care) and CDA scholarship funds.

The field of family child care training is emerging at this time. We have only begun to sense its potential and how it will evolve in those communities where it receives serious attention and substantial resources.

Ensuring Small Group Size and Low Adult-Child Ratio

In most family child care homes, group size and staff ratio are synonymous because there is only one caregiver. Most family child care homes have fewer than six children with one provider (Kontos, 1992). Hofferth and Kisker (1992, p. 46), analyzed the differences in group size between center- and home-based programs, summarizing their findings as follows:

> Group sizes are considerably smaller in family day care homes than in center-based programs, and smaller in non-regulated than in regulated family day care. The average group size in family day care is about three or four children, compared with a group size of 16 children in center-based care.

Small numbers of children per adult are associated with higher quality in centers and apparently in homes. Large numbers of children hinder the quality and frequency of provider-child interactions (although optimal quality for children over a certain age may require some minimum-number as well). Even when providers are skilled and energetic, they must spend much of their time on custodial care (physical care such as feeding and diapering or toileting) if they have large groups of children. The sustained interactions and intentional activities which promote children's development require time.

Regulation

State regulation is the traditional strategy of policymakers who want to address the adequacy of care received by children, although strong anti-regulatory sentiment coexists in relation to family child care in most states. Regulation tends to focus on group size/staff ratio and health and safety requirements — character-istics associated with protection that can be readily defined. As described above, there is also a current trend for states to add training requirements. Provider and family physical exams and criminal record checks are becoming common across the states, as is the right of enrolled parents to visit unannounced. A few states also set minimum age requirements for providers or require high school diplomas. In no state does regulation promote high quality care; it simply sets a minimum floor of quality. No national standards for the regulation of child care have been established.

The Current Situation

Approaches to regulating family child care have emerged state by state. No national standards exist, and many providers are in fact unregulated, legally or illegally.

State Approaches to Regulation. Forty-two states regulate family child care in some way (Morgan, et al., 1993), but because each state has invented its own method, approaches to regulation differ widely. Some license homes, others register them. While the definition of these terms varies and overlaps, licensing usually involves home visits to verify compliance with the regulations. States that register providers tend to depend on the provider's signed statement that standards have been met — these states do not usually monitor providers unless a complaint has been filed. Some states monitor a specific percentage of randomly chosen-homes each year. According to the Children's Defense fund,

> Nine states do not regulate family child care in any way, and several others require only self-certification. Many states exempt providers caring for specific numbers of children. Even the strongest set of standards will have little impact on the quality of care if most family day care homes are exempt based on the number of children they serve.
>
> - Twenty-two states exempt family day care homes serving five or fewer unrelated children from mandatory regulation under a system that includes inspections.
> - A total of 36 states exempt family day care homes serving three or fewer unrelated children from mandatory regulation under a system that includes inspections.
>
> (Adams, 1990, p. 9)

Thirty-nine states regulate large or group family child care homes, typically limiting group size to 12 or more children with an assistant to help the provider (Morgan et al., 1993). (In my experience, group family child care providers tend to be relatively more professional in their business and program practices, and they usually make higher incomes than small-home providers.)

Unregulated Family Child Care. Most providers are not covered by regulation, for a variety of reasons. Although homes are licensed or registered by 43 states, a sizable majority of family child care providers in these states are unregulated (Kontos, 1992). We do not have accurate information about how many of these unregulated providers are legally exempt due to the small number of children in their care.

Very few of the unregulated providers in the National Child Care Survey were illegally unregulated, although it is reasonable to assume that illegal providers were more likely to decline to participate in the study. Contrary to common expectation,

> the average group size is small for both regulated and nonregulated family day care providers, with ranges from four to seven children in regulated family day care and two to four children in nonregulated family day care.
>
> (Hofferth & Kisker, 1992, p. 46)

Hofferth and Kisker summarize their findings about unregulated homes as follows:

> They are smaller, they are more available (but harder to locate), they charge lower fees, they make less money at it, they care for children for fewer hours per week, and they are more likely to care for sick children and to provide evening care. Nonregulated providers are less likely to consider themselves professional providers. For example, they are more likely to say that they provide care as a favor for relatives or friends than are regulated providers. In other respects they are very much like regulated family day care providers.
>
> This may surprise many readers, as nonregulated family day care is often assumed to be inferior at best and dangerous at worst. However, . . . most family day care providers are not operating illegally.
>
> (Hofferth & Kisker, 1992, p. 53)

Other studies have tentatively reached similar conclusions (Kontos, 1992). A more definitive comparison of regulated and unregulated care will be available within a few months from the Families and Work Institute's study.

Issues in Regulation

Although a large proportion of the resources that states allocate to family child care are spent on regulation, we have little information about the benefits of this strategy. No comprehensive studies have compared the effects of the diverse regulation practices of the states. There is little evidence that regulation improves quality — the weak relationship between the two may be caused by a tendency for those providers who offer a good-quality program to become regulated as well. Regulation is better seen as a form of child protection, establishing a floor of quality. Furthermore, there is no consensus about the form state regulation should take.

The Level of Standards. Major debates occur about the following questions pertaining to the level at which standards should be set:

> *Under what conditions, if any, should programs be exempt from regulation?* Should the state regulate the basic health and safety of children in the paid care of non-relatives, parallel to regulation of restaurants and hairdressers? Or should the state refrain from intruding upon the privacy of people's homes? Should child care under certain conditions be designated a private arrangement between the provider and the child's parents?[8] Should relative care be exempt from regulation even when it is publicly funded? Current regulations reflect a diversity of opinion on these questions.
>
> What limits, if any, should be placed on the total number of children (group size)? As discussed above, we know that group size is a predictor of quality in child care centers, and it appears that large groups are associated with low quality in homes as well (Kontos, 1992). States vary broadly in the limits they set for the number of children that one provider may care for at any given time.
>
> Many states also limit the number of infants and/or toddlers per home, though these limits may be very high:
>
> > Two-thirds of all states allow a single caregiver to care for three or more infants and toddlers in a family day care home. In many states, at least some of the children of family day care providers are not included in these limits, raising actual child-to-staff ratios in family day care homes even higher. . . .
> >
> > Thirteen of these states allow five or more infants (younger than two) to be cared for by a single caregiver, sometimes with additional older children. (Adams, 1990, p. 32)
>
> Providers agree that very young children require more individual attention than preschoolers; they show a wide range of opinion on the number of children that should be allowed per provider.[9]

Wisconsin has taken a creative approach to age and group size limits, allowing different numbers of children depending on their ages, as shown in Figure 2. Texas uses a similar strategy.

Figure 2. Wisconsin Licensing Limits on Number of Children per Provider, by Age

Children Under 2 Years of Age	Children 2 Years of Age and Older	Maximum Number of Additional Children in First Grade or Above in Care for Fewer Than 3 Hours a Day	Maximum Number of Children per Provider
0	8	0	8
1	7	0	8
2	5	1	8
3	2	3	8
4	0	2	6

Providers and families like the flexibility of the this approach and seem to be able to handle its complexity. The approach also allows providers to respond to market demand for the care of children of different ages (especially infant care, which is more limited in most states).

The issue of group size is directly related to the issue of compensation (see below). Some providers oppose regulation limits, arguing that they should be allowed to enroll large numbers of children. But when asked their reasons, these providers almost always report that they need to make a decent income; they usually agree that they cannot do a good job with more than six or eight children. The trilemma of quality-compensation-affordability applies to family child care just as it does to centers. These variables are dynamically interrelated. When a state limits group size, it affects the incomes of providers and/or the affordability of care for parents. In turn, these factors influence the quality of children's care as well.

Reasonable health and safety regulations combined with pre-regulation home visits appear to have significant influence on providers. For example, in preparation for regulation, providers install smoke detectors and fire extinguishers, remove the poisons from under their kitchen sinks, and put safety gates at the top and bottom of their stairs. Many states now have First Aid and Infant-Child CPR requirements, which most providers as well as parents support.

Unfortunately, some of the most important regulatory safeguards are difficult for some providers to meet. For example, urban apartments often do not have satisfactory fire-escape access, and they may have insufficient space to meet licensing standards; consequently many urban

providers must avoid regulation. Thus, urban parents are often denied the choice of licensed family child care, and race and class discrimination are tacitly built into licensing and support delivery.

Standards may seem excessive or overly rigid to providers, resulting in non-compliance. For example, even providers who agree with group size limitations may violate them when the sibling of one of their current children needs emergency care. Or providers may feel it is excessive to wash all the toys in a bleach solution every night and to provide paper towels or separate towels for each child. What they do not do for their families they are likely to feel is unreasonable for family child care, unless they receive convincing information for the reasons behind the requirements. Such information should be included in licensing orientation.

Monitoring and Enforcement. Many states do not effectively monitor or enforce compliance with their family child care regulations. As described above, an unknown majority of providers are unregulated, whether legally exempt or not, and whether aware or unaware of their illegal status. Furthermore, recent budget cuts in many states coupled with increasing numbers of provider applications have resulted in fewer licensing staff members being assigned to more homes. Home visits to monitor compliance have been reduced or eliminated. In some states with fairly strong licensing requirements, most monitoring occurs only in response to complaints. In such cases, states give parents the illusion that their children have more protection than they actually do. A few states have programs to encourage parents, who are in the homes every day, to take responsibility for monitoring compliance. In 1986, 23% of states required providers to give information to parents about what they as parents had a right to expect from regulated care; 19% of the remaining states prepared similar literature for parents but did not mandate its distribution (Modigliani, 1986).

Lax enforcement breeds cynicism: once a provider breaks one rule, is she more likely to break another? Do some providers not pay taxes *because* they are not regulated? Do those providers who do not wash toys every night feel less compelled to wash their hands after changing diapers?

Isolation and the "Underground." Providers who are unregulated, legally or illegally, are especially isolated from other providers and support services. (When states exempt providers caring for small numbers of children, they promote their isolation.) Unfortunately, some providers remain isolated in order to avoid

regulation. Their reasons for avoiding regulation include the following:

- They want to avoid reporting their incomes and paying taxes.
- They do not want the government to intrude into the privacy of their homes.
- They believe their homes might not "pass inspection."
- Their immigration status does not permit them to work.
- They are not aware of the regulatory requirements.

Evasion of income-tax policies and licensing laws has contributed to keeping family child care unregulated, isolated, and invisible.[10] In turn, this prevents providers from participating in the Child and Adult Care Food Program,[11] and from receiving training, subsidies for low-income parents, parent referrals, and other benefits available to regulated providers only. Each of these consequences of non-compliance would be expected to be associated with lower quality of care.

In sum, regulation should be seen primarily as a mechanism for child protection rather than as a support for quality, and it must be enforced for all providers to achieve this purpose. But regulation does promote quality when it brings providers to training. Furthermore, it often promotes providers' first steps toward professionalism and places them upon a mailing list which disseminates information and reduces isolation. Participating in training and becoming regulated both function to bring providers into a mode of continuing professional development.

Continuing Professional Development

The professional development of family child care providers should be added to the list of indicators of quality of care (Modigliani, 1993a). Intertwined with training and regulation, professional development usually leads to a greater sense of responsibility for offering high-quality programs. When unregulated providers spend time with regulated providers, they often decide to become regulated. After providers take one training class, they usually want to take another. As providers share their thinking at association meetings and support groups, they help each other become more reflective about the quality of their programs. Experienced providers serve as role models and experts for newer providers, while they build their own self confidence and leadership skills.

Emerging from some of the Family-to-Family communities are common sequences of family child care professional development activities. They constitute a career development ladder with a range of options. While varying from one

community to another (Modigliani, 1993b), they tend to share the following components:

1. *Orientation and Regulation.* Sponsored by the state licensing staff or subcontracted to a child care resource and referral agency, these one-time classes typically include the essentials of regulation, health and safety, and parent contracts. Increasing numbers of states also include First Aid and Infant/Child CPR as part of orientation. Providers are encouraged to become regulated before they start caring for children (though many become interested in regulation at a later time and should be welcomed with amnesty).

2. *Basic Training.* Sponsored by resource and referral agencies, two-year colleges, systems, or provider associations, these multi-session classes usually focus on basic child development and developmentally appropriate activities; observing, supporting, and extending play; basic business practices; and working with parents. When funding is available, the classes tend to offer supervision and technical assistance through mentors or home visits.

3. *Preparation for Accreditation and/or CDA Credential.* In communities where a sufficient number of providers have completed basic training, some of them usually want to work toward accreditation — through the National Association for Family Child Care or another group — or the CDA Credential (see Accreditation, below). Most providers find they need the structure and technical assistance of a class to help them achieve their accreditation or credential.

4. *Advanced Training.* Sponsored by community or four-year colleges, academic-credit courses cover a wide range of content reflecting the broad knowledge base relevant to this occupation, such as infant-toddler development, small business administration, and public policy in early care and education.

5. *Mentorships.* Providers gain much from peer role models "who really know what they are talking about." By recognizing competent providers, mentorships add an important component of career development and community recognition.[12]

6. *College and Advanced Degrees.* As described above, providers can benefit from academic training just as much as center teachers and directors.[13]

7. *Advocacy.* Providers who have participated in a range of professional development activities often become advocates, working with an association or other professional organizations to improve the field.

Communities that sponsor appropriate training have found that when providers complete a basic training course, many seek additional training and professional affiliation. For example, graduates of Family-to- Family have started several local provider associations so they can continue to work together. These associations usually sponsor informal training, support, and advocacy efforts (Page, 1993).

Infrastructure Support

Five types of agencies support the quality of family child care at the community level. These five prototypical agencies form a critically important infrastructure for supporting quality in any community. They are:

1. Provider Associations
2. Resource and Referral Agencies
3. Licensing Agency
4. Food Programs
5. Systems

Each of these five components of the infrastructure should be strong, effective, and work in collaboration to deliver the various kinds of services described — training; mentorships; newsletters; parent consumer education; accreditation initiatives; advocacy initiatives; resource rooms and lending libraries; toy, equipment, and home improvement grants; technical assistance such as warm lines, insurance pools, and bulk purchasing. Although no community offers all of these functions, many communities are expanding these kinds of services for providers.

Provider Associations

Professional associations are neglected in the infrastructure of many communities. Ideally, each community has a provider association and an AEYC — an affiliate of the National Association for the Education of Young Children (NAEYC). The provider association should provide support, training, advocacy and other member services and professional development activities for providers, and should be affiliated with regional and state-wide providers as well as the National Association for Family Child Care (NAFCC). The AEYC should provide similar functions for all early childhood professionals in their community including providers, whom they often exclude.

Resource and Referral Agencies

A community resource and referral agency (R&R) is the most logical organization to help parents find good quality child care. Ideally the R&R provides parent education in conjunction with child care referrals, supporting parent choice. Real parent choice requires that each parent has several options to choose among that are convenient enough, affordable enough, appropriate for children and families in personal and cultural style as well as program. The best R&Rs identify weaknesses in the child care system and sometimes coordinate the efforts to improve them. R&Rs are in the position to insist that family child care as well as center-based care benefit from quality improvement initiatives.

Licensing Agencies

The state agency that regulates child care should relate to providers at the community level through staff members who are friendly and supportive, helping providers comply with regulatory standards. When licensers act like police, providers evade regulation. When licensers are invisible and enforcement is lax, providers do not pay attention to "the regs." When licensers are seen as technical advisors, they help providers meet standards, feel motivated to meet standards, and encourage other providers to do so.

Food Programs

Child and Adult Care Food Programs can support quality at the community level, not only by ensuring good nutrition but also indirectly through the other kinds of professional development that are facilitated any time providers come together. In some communities a staff member can deliver other support services in conjunction with Food Program activities (e.g., home visits, provider conferences). Unfortunately, some states forbid such "intermingling."

Systems

Systems, or "networks" or "satellites" as they are also called, provide enhanced services to some selected group of providers. Systems may be funded by a state or municipality to support providers who serve low-income families or those whose children have special needs, or by an employer as a work/family benefit, or others who want to offer special family child care services. Typically in these systems, paid staff deliver training, supervision, and other supports.

In sum, training, favorable group size and adult-child ratios, regulation, continuing professional development, and infrastructure support are strategies for increasing quality. Initiatives in any one of these areas tend to promote the others. When providers leave the isolation of their homes to join professional activities, for example, they are likely to improve the quality of their programs in other ways: becoming regulated if they are not, joining other professional activities. They also begin to overcome — or become more resistant to — the several negative factors which function as barriers to quality.

PART 3. BARRIERS THAT INHIBIT QUALITY IN FAMILY CHILD CARE

Five related factors work against the quality of family child care. Three of these pertain to the provider: low compensation, low social status and cultural devaluation, and low retention of providers in their jobs. The fourth, which relates to parents, is affordability, and the fifth is consumer financing, pertaining to both parents and governments. These factors limit the number of potential providers entering the field, cause dissatisfaction among existing providers, and cause them to leave the occupation for other kinds of work. They also appear to restrict parents' access to quality care and cause lower-income families to receive lower-quality care (this finding has been documented in center-based care in Whitebook, et al., 1989). It should be noted that all these barriers hinder the quality of center-based care as well. The problems of child care exist in all sectors.

Low Compensation

We do not yet have evidence concerning the relationship between family child care provider income and the quality of care offered, though this research is underway.[14] According to the National Child Care Staffing Study, child care centers that pay higher wages tend to offer higher-quality care and have staff who seek training and support and plan to continue offering care (Whitebook et al., 1989). There is every reason to expect that these correlations hold in family child care as well as center-based care.

Income

The average annual income of regulated providers, before expenses, was approximately $10,000 in 1990, according to the National Child Care Survey (Hofferth & Kisker, 1992). But to calculate net income, that is, effective income, we must deduct expenses; unfortunately we do not yet have accurate data documenting

the costs of providing care. Preliminary results from the Economics of Family Child Care Study (Modigliani, Helburn, Culkin, & Morris, in progress) suggest that costs will average at least $3000, which would suggest that the median net income of providers in 1990 was no more than $7,000.[15] Because most providers work about 55-65 hours per week, 50-52 weeks a year, this average income is well below the minimum wage.[16]

When compared to the wages of other American workers with similar levels of education, experience, and responsibility, family child care as an occupation is among the most inequitably paid of all.[17] Contributing to the problem, regulated providers have not regularly raised fees to keep up with inflation, thereby causing "a substantial decline in the real wages of . . . [providers in] home-based programs over the past 15 years, despite their increased levels of education and training." (Hofferth & Kisker, 1992, p. 49)

Low provider incomes hinder quality. Some providers accept as many children as possible so they can make a sufficient income, and we have seen that larger numbers of children are associated with lower quality. The lower the income, the less providers can afford to pay for training, for needed equipment or toys, or for substitutes when they are sick, need to take a vacation, or work with others to improve the field. We will see below that low incomes also cause a high drop-out rate in the occupation.

Low expectations for income are self-fulfilling; providers believe that parents and other funders cannot afford higher fees, sometimes in spite of evidence to the contrary. Similarly, they may believe, perhaps rightly, that parents will not compensate them for offering higher quality care.

Fringe Benefits

Because nearly all providers are self-employed, they do not receive employer fringe benefits. According to preliminary findings of the Economics Study (Modigliani, et al., in progress), most providers are not covered by even the most basic medical insurance, excluding Medicaid, unless they are included in their spouses' policies. The same is true for retirement savings. Most providers do not charge for paid holidays, vacation time, or sick days. Some close for a few holidays and perhaps take a week or two of vacation. In contrast, a small fraction of providers work for employers or systems — such as colleges, hospitals, or public institutions — and they sometimes get the same benefits as comparable workers in the parent institution (Modigliani, 1993a).

Although we have no direct measures of the effects of these poor working conditions, logically they would be expected to interfere with quality of care as well as the retention of providers. When asked what they do when they are sick, providers in the Economics Study (Modigliani et al., in progress) are reporting either that they do not get sick, or that they don't admit to the parents that they're sick. Self-employed workers should theoretically pay for health benefits from their own profits, but the low incomes in this field rule out that possibility for most providers. If the earnings of family child care workers are increased, providers will be able to purchase health insurance and substitutes, as well as to save for their retirement.

Income Taxes

Income taxes are directly related to compensation and are the source of controversy in this field. In the past, most FCC providers — about 80% of all providers according to one IRS study (Lewin, 1991)[18] — have neglected to report their incomes to the IRS. This situation has begun to change with the new tax law requiring that parents report their providers' Social Security or identification number to the IRS if they claim the Dependent Care Tax Credit. Providers voice several reasons for their non-compliance with the tax law: they earn too little income to feel that they should have to report it; those whose incomes have been only marginally satisfactory will be likely to go out of business if they have to pay taxes; and they are put off by the burden of the elaborate record- keeping and calculations required. When non-compliant providers refuse to give their social security or identification numbers to parents, they jeopardize the main source of governmental child care support. A similar loss occurs when parents forego participation in employer dependent-care-assistance plans.

According to preliminary findings of the Economics Study (Modigliani et al., in progress), very few providers understand the tax law pertaining to this very small business. It is extremely complex — identical to that for child care centers, stores, or any other small business. Many providers simply do not deal with it. Even when they report their incomes to the IRS, most do not claim many of their legitimate business expenses. It may be that a majority of providers would not owe much if they took the time to calculate their taxes properly, claiming all the legal deductions for their home and business expenses. This is one area where incomes could be increased through appropriate training.

Low Social Status and Cultural Devaluation

The lack of respect for family child care as an occupation discourages many current and potential providers. Society at large and many parents using family child care see this work as "just babysitting," as work for someone who cannot find anything better to do. Riley and Rodgers' findings from a study of licensed center- and home-based caregivers in Wisconsin explain the frustration voiced by providers across the country:

> Virtually every child care teacher (in both centers and homes) disagreed with the statement "Providers are basically just baby-sitters," and 96% stated they believe that "Day care providers strongly influence child development." . . . In stark contrast, 93% of child care teachers [in homes and centers] believe that the public views their work as baby-sitting, and only one in five (21%) believes that the public perceives child care is influential on a child's development. . . .
>
> One hundred percent of family day care providers and 96% of child care teachers believe that "child care is a profession just like social work and education are professions." In comparison, only 6% perceive the public having the same view. (1989, p. 42)

The low status of providers is reflected in and perpetuated by their lack of influence at all levels and in all sectors. For example, decisions pertaining to family child care are usually made by groups that do not include providers. Provider associations and support groups are therefore important not only because they remind providers that their work is important despite their lack of recognition from others; associations also gain political influence and allow providers' voices to be heard.

The low status of family child care as work is caused in part by the low incomes, as described above — in this society, the income of an occupation is strongly associated with its status. A related cause is the lack of educational requirements, implying that no special skills are needed; providers with college coursework hear that they are "wasting their educations." But the most basic causes are cultural: the cultural devaluation of young children in this society coupled with the devaluation of traditional women's work (Modigliani, 1993a). Meaningful solutions to the problems described in this paper will depend upon nothing short of a major cultural revaluing of our young children, their early years, and their care and education.

Low Job Retention of Providers

The number of years family child care providers stay in business is difficult to document because of a lack of longitudinal research in child care. Various studies have estimated 37% to 59% of all providers quit each year, with higher drop-out rates among unregulated providers (Kontos, 1992).[19]

The high drop-out rate in this field is also closely related to its poor compensation and low status. Three research projects have examined the factors that influence provider recruitment and retention, which in turn influence supply as well as quality (Lawrence, Brown, & Bellm, 1989; Modigliani, 1993a; Riley & Rodgers, 1989). Together the studies indicate that of all preventable causes, the expectation of earning low income is the greatest barrier to recruitment of providers, and the actual experience of earning low and unstable income is the greatest barrier to retention. This means that the supply of family child care is hindered by the low incomes. The high drop-out rate in the occupation also wastes dollars spent on training and other government or employer investments in providers.

The high turnover in family child care causes many young children to be cared for by a series of caregivers, at an age when healthy development demands continuity in relationships. High turnover, associated with lower quality in child care centers (Whitebook et al., 1989), is theoretically even more disturbing in family child care. Interruptions in child care arrangements are disturbing to parents as well as children, and to providers and their families. When a provider stops offering care, each family must usually "make a totally new child care arrangement with a new physical environment, a new set of rules and expectations, and a caregiver who may be a total stranger" (Lawrence, et al., 1989, p. 47).

Too often, when people who might otherwise enjoy working with young children see their jobs as "nothing but dead end and heartbreak," they leave child care for what they call "real jobs," with fringe benefits and promotion opportunities as well as better incomes (Modigliani, 1993a). Those who continue offering care subsidize and thereby support and sustain the current, inadequate situation through their low wages and long hours.

The Cost of Family Child Care

Economists distinguish between the current market costs of child care and the full production cost, which includes the value of hidden subsidies. A wide discrepancy exists between these two approaches to defining cost.

Current Market Cost

The average fee paid by parents to regulated providers in 1990 was $1.61 per hour, compared to $1.48 for unregulated providers, and $1.59 for child care center teachers. Fees tend to be higher in the Northeast and West and in urban and suburban areas, and lower in the South, Midwest, and rural areas (Willer et al., 1993). Preliminary data from the Economics Study suggest that expenses average a minimum of $3,000 per year and perhaps significantly more (Modigliani et al., in progress).

The Full Cost of Care

The true cost of child care is obscured by invisible, unpaid subsidies in the form of providers' undervalued labor and the in-kind contributions of their family members.[20] Since governmental subsidies are usually indexed to market rate or some fraction of it, federal, state, and municipal governments perpetuate and even exacerbate the inadequate financing of child care, apparently subsidizing providers at less than minimum wage (Modigliani et al., in progress). If child care workers received compensation comparable to that of other workers at their education levels, previous experience, and job responsibility, the current cost of child care would probably be doubled or more.

Market Failure

The cost of family child care and its supply and demand are influenced by market forces. But child care markets do not respond to supply and demand as readily as they "should" according to market theory.[21] Primary causes of the discrepancy appear to be the devaluation of young children's experience and traditional women's work (Modigliani, 1993a). Parents and governments lack information about child care costs and their relation to quality of care; economist Rachel Connelly notes that it may be difficult for parents to judge quality but, theoretically, higher quality care is a "merit good" — worth more because it contributes to the production of higher quality children (1988). High quality child care is a "social good" as well, benefiting the society as a whole and employers dependent on the quality of the workforce, but neither contributes substantially to its financing (Culkin, Helburn, & Morris, 1990; Hartmann & Pearce, 1989). When parents are informed about these factors, they are sometimes the first to suggest that fees be raised (Modigliani, 1993a). Thus, parent and public education about the true

value of early childhood and quality child care is needed. A few related efforts are under way, most notably those being led by the Child Care Aware Campaign sponsored by the Dayton Hudson Foundation.

Lack of Awareness and Organization Among Providers

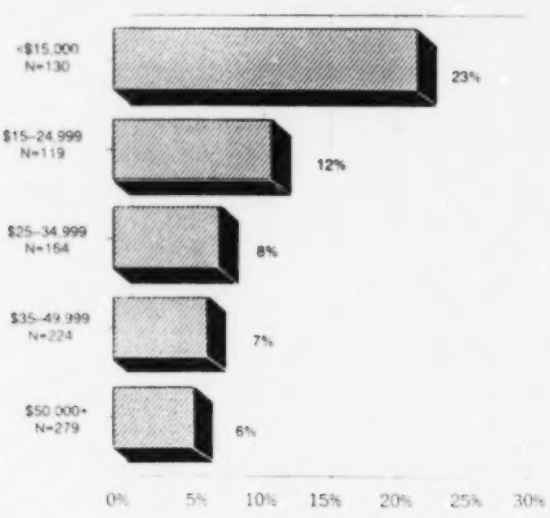
Providers and other child care professionals are reluctant to face these economic problems themselves, let alone explain them to unsympathetic outsiders. The Economics Study (Modigliani et al., in progress) is finding that many providers sacrifice their own incomes so as to keep their fees affordable for parents.

The lack of organization among providers perpetuates their invisibility and lack of awareness. Organization in this field is proving particularly difficult, because providers work such long hours that they do not usually have energy to devote to other activities beyond their families. Their low incomes prevent them from hiring a staff person to carry out this work.

The Affordability of Family Child Care for Parents

While current market fees are insufficient to fund adequate incomes and benefits for providers, they are also painfully expensive for low-income families. Figure 3, on the next page, presents the Demand and Supply Studies' findings for the percentage of income spent on child care by working families with a child under age five.[22]

Figure 3. Mean Percentage of Family Income Spent on Child Care



Source: National Child Care Survey 1990 (Reprinted from Willer et al., 1991, p. 32)

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This chart shows that parents earning under $15,000 annually (usually single mothers) pay *one-quarter or more* of their earnings for child care, leaving them less than $12,000 for everything else. In contrast, parents earning over $50,000 pay *only one-seventeenth* of their earnings for care. Data from the same studies show that *upper-income families actually pay little more for child care than do lower-income families* (Hofferth, Brayfield, Deitch, & Holcomb, 1991) — surprising, in light of how much more upper-income people spend on their housing, cars, food, clothing, and almost everything else.

Lower-income people, especially those in the lowest quarter of the population, cannot afford to pay current market rates. They have experienced substantial declines in their standard of living since 1973 (Wilson, 1987). Families receiving the lowest 25% of income have trouble meeting even the most essential expenses (Schor, 1991). The feminization of poverty has produced an increase in the number of young children in poverty. It has hurt single mothers and their children most, and especially black single mothers (Litan, 1988). In 1990, fully 40% of children in families where the head of household was under age 30 lived in poverty, double the number in 1973 (Children's Defense Fund, 1992).

Is our national child care situation a dramatic case of separate, unequal education? The National Child Care Staffing Study (Whitebook, et al., 1989) showed that, for center-based care, children of lower-income parents who do not receive subsidized child care (with its quality supports) received a lower quality of care than those whose parents can afford to pay more for their care. There is every reason to believe that same will hold for family child care.[23] The lack of public interest in child care prevents us from recognizing the dramatic discrimination that is being perpetuated against young children and their families.

And yet, upper-income families could afford to pay more than one-seventeenth of their incomes. They could pay the full cost of their child care, as described above, instead of being subsidized by providers' inequitably low wages. How much *should* families pay? Juliet Schor concludes that families with incomes in the upper 40% are well-off (1991) — it would be logical to conclude that they could afford to pay the full cost of their children's care. Using similar reasoning, the state of Minnesota has implemented a sliding scale to subsidize child care fees for parents who earn up to 110% of median income. A sliding scale is a cost-effective way to subsidize families flexibly, according to their incomes (Lookner, 1991). Unfortunately, in many states the sliding scale does not slide nearly high enough, or

parents have to wait months or years to gain support.

Child care is expensive, despite its underfunding. Another cause of this paradox is the labor-intensity of the work — the compensation of each caregiver must be compiled from only a few parents' fees or public subsidies, while scores of consumers pay the higher wages of one parking lot attendant or kennel worker. All the property owners in most school districts share the cost of public school students' education — regardless of whether or not they have children in public schools — sometimes with additional state and federal taxes. Young families have to pay the entire cost of child care, usually with no help, during the years when they are at the lower end of their earning power. Ironically, when families later incur college expenses, significantly more government assistance is available. If child care fees for upper-income parents are raised enough to approach the full cost of care, it is likely that some of these influential parents will become interested in advocating child care as a governmental entitlement for children of all income levels, like public school. They will remain silent as long as child care providers continue to subsidize their care (Morin, 1989).

Can parents afford to pay more for child care? Rich ones can, poor ones cannot. The question should be rephrased: How much can parents at different income levels afford? The very real inability of lower-income parents to pay today's child care fees, combined with the lack of awareness on the part of upper-income parents about the value and true cost of high-quality care, have resulted in a system of early care and education that is grossly underfunded.

The Inadequate Financing of Family Child Care

We have seen that the quality of family child care has been jeopardized in several ways by its insufficient funding. Lack of money forces some providers to enroll too many children. It forces providers to skimp on toys, materials, and equipment, and to otherwise shortchange the quality of care. It forces providers to quit their jobs even though they like the work. The resulting high turnover is particularly harmful to very young children who need stable, consistent relationships to support healthy development. Current wages and benefits are not attractive to well educated workers, and keep them from choosing this work.

Why is child care so underfunded? One primary reason is its devaluation, as discussed above. Sally Lubeck, quoting Norton Grubb and Marvin Lazerson, notes that American social policy in effect redistributes income from young families to the wealthy, the childless, and the elderly:

> The United States, drawing on a different social history [from that of European countries], has reconciled the tension between private and public responsibility very differently than have the nations of Europe. The American construction of public responsibility to families has taken two forms. The first . . . has been to justify public action only when there is evidence that parents have failed. The second . . . [in theory has been to] "compensate for parental deficiencies without intruding into private families and without intervening into the private economy to change the material conditions of family life." (Grubb & Lazerson, 1982, p. 43)
>
> (Lubeck, 1989, p. 345-346)

The discrepancy between rhetoric in the United States about the value of young children, "our most precious resource," and the facts of child care financing point to a major contradiction between our national will and cultural values. The current market costs of family child care are paid almost entirely by parents, whether they can afford them or not. What about government and employers? The following two sections consider each of these funding sources individually and cite promising practices in each sector.

The Lack of Government Support

Since many young children spend approximately half of their waking hours in child care — and assuming the quality of their early experience will influence the quality of the remainder of their lives and the lives of others around them — the quality of child care is an indicator of a nation's well-being. Parallel to the question of whether families are spending enough on child care is the question of whether the public, at all levels of government, is spending enough on child care compared to the other commodities and services that compete for public financing.

Nearly every industrialized country in the world, and many "Third World" countries, spend more per capita than does the United States to support universal child care and education as well as paid parental leave for parents of newborn babies (Kamerman & Kahn, 1991; Kamerman, 1991). But the U.S., less inclined toward social responsibility, usually leaves it to parents to find their own child care and pay for it by themselves.

There is some federal support for child care. The greatest proportion of federal tax dollars spent on child care goes to the Dependent Care Tax Credit to benefit parents using child care, especially middle-income parents. Other sources of federal support take the form of subsidies for low-income or at-risk families through the Child Care and Development Block Grant, the Social Services Block Grant, Title

IV-A, and the Family Support Act. Unfortunately, in most states each of these programs is administered by a different office, leaving an inefficient and ineffective non-system. A few states are attempting to deliver "seamless services," where community-level coordination provides consistency and smooth transitions from one child care setting to another.

As seen in the section on the cost of family child care, governmental subsidies are often set below market rate and appear in some cases to pay providers less than the minimum wage. As a result, many providers choose not to enroll low-income families so as to earn decent incomes. A few states have attempted to raise reimbursements, using market rate data collected with CCDBG funding. Two states are studying the feasibility of offering group health insurance to providers (Child Care Employee Project, 1992).

In sum, the U. S. government's low level of involvement in child care is inadequate to ensure good quality, thus handicapping society at large.

The Lack of Corporate Support

What about employer support for family child care? Despite the visibility in the media of employer-sponsored programs, only a small number of corporations make any contribution to their employees' child care needs (Families and Work Institute, 1993).[24] When support is offered, the most common form is assistance with child care referrals, usually contracted through a child care resource and referral agency (Joseph & Ward, 1991). Exemplary employer models are described in Pat Ward's *Employers and Family Day Care* (1991).

By far the most high-quality, comprehensive model of employer support for child care has been developed by the U. S. Army. The Army's compensation and training project, established in concert with the Department of Defense, is consistent with the federal civil service personnel system. To recruit and retain quality staff, they offer "competitive entry-level wages and increased pay based on completion of on-the-job training, demonstrated classroom competency and specialized experience with young children." (Army Child Development Services, no date, p. 2.) Benefiting from tax-payer dollars, the Army's model addresses many of the problems in child care today — whether or not the same provisions apply to family child care providers is decided by individual base commanders.

Most notably, the Army has uncoupled the link between what parents can afford to pay and what child care workers deserve to earn. Parent fees are determined by a sliding scale; provider compensation is determined by a scale that

rewards education and experience. Experienced full-day teachers with bachelor's degrees earn between $21,906 and 28,476. Entry-level teachers with a high school diploma or G.E.D. earn between $12,905 and 13,640. The unusually good benefits package includes comprehensive medical and dental benefits, paid vacation and sick leave, and a retirement plan based on compensation and years of service. Seniority is transferable from one base to another (M.-A. Lucas, personal conversation, November, 1992).

Another notable employer-supported family child care initiative is Family-to-Family, previously mentioned in this paper. Sponsored by Mervyn's, Target Stores, and the Dayton Hudson Foundation,[25] the initiative supports the quality of family child care in 32 communities through training, accreditation, and consumer education. Another is the California Child Care Initiative. Led by Bank America and supported by several other corporations and municipal governments in a large public-private partnership, the initiative has carried out a state-wide recruitment and training effort for family child care (California Child Care Resource and Referral Network, 1993). The consequences of an effort of this scope and quality can be seen in the unusual level of professionalism of California providers. Both of these initiatives have laudably supported the quality of care for their entire communities, not simply for their own employees.

Corporations profit from the increased hours that mothers and fathers work today compared to two decades ago, hours that have been gradually eroded from family and leisure time (Schor, 1991). Neugebauer (1987) estimated that in one year, child care center staff subsidized American businesses by $2.4 billion by caring for employees' children for less than comparable wages; a similar contribution is made by family child care providers. Some of this subsidy could logically be shifted to employers. Ideally, corporate taxes would fund government-sponsored programs to support quality child care, because, as corporations are the first to admit, they are not in the business of child care. In addition, employers could assist their workers in becoming effective child care consumers.

The Absence of a National Alliance for Early Care and Education

One final barrier inhibits the quality of family child care and center-based care as well: there is no organized national political constituency to advocate quality. A comprehensive system of early care and education will become politically viable when and only when parents — fathers as well as mothers — and child care professionals join together to demand it. At this time these two groups do not work

together. Early childhood professionals, when they advocate alone, are seen as promoting their own self-interest, and their numbers are too small to constitute an effective power base. Parents and caregivers need to recognize and overcome the significant tensions between them before they can work well together (Modigliani, 1993a).

At the same time, the different sectors within child care are disorganized and sometimes in conflict. For-profit child care centers may oppose the efforts of non-profit groups; family child care may be in conflict with center-based caregivers. Resource and referral agencies may be at odds with provider groups. Head Start functions in relative isolation.

Only when parents, child care workers, and other caring citizens join forces in a major, long-term national drive will we have the political influence to gain political support sufficient to rectify the fundamental problems of child care. This will not be possible until parents and the public at large understand more about the value of a young child's daily experience and, in turn, the value of child care. Thus, we need a major national campaign to educate parents and the voting public about the value of child care and to draw attention to the needs of the field.

In conclusion, family child care has the potential of offering our young children the kind of individual attention and customized, educational programs that help them to thrive and to maximize their potential. Training and, to a lesser degree, regulation are effective strategies for supporting the quality of family child care. The current trends toward professional development in this field appears to promote quality as well.

Good caregiving requires substantial funding for provider training and subsidies for low-income families. But unfortunately, the quality of care and education received by our nation's children is left to market forces. Current parent fees and government and corporate subsidies do not begin to cover the full cost of good quality child care. Low earnings, lack of benefits, and low social status discourage workers and perpetuate the devaluation of the work.

Child care is an occupation in trouble. Assuming that the quality of children's care and education derives primarily from the quality of their caregivers, it is not an exaggeration to say that a critical component of the well-being of our nation is dependent upon a workforce which, at this time in history, is situated at the bottom of our occupational status and pay hierarchy. Taking care of young children is an extremely labor-intensive activity requiring skill and responsibility.

Other efforts to support the quality of child care will be handicapped so long as the occupation pays incomes and benefits that do not attract and retain a competent labor pool. We have not begun to recognize and compensate the true value of this labor.

Exacerbating the situation is the United States' extreme devaluation of child care and young children's daily experience. Our cultural valuation of rugged individualism and individual self-sufficiency works against public support for children and families. Adequate financing to support the full cost of quality child care will require that child care consumers — parents and governments — come to appreciate the value of early care and education. The final part of this paper describes a comprehensive solution to the problems of quality in family child care.

PART 4. A VISION OF SUPPORT FOR THE QUALITY OF FAMILY CHILD CARE

Comprehensive support for the quality of family child care will require efforts to be coordinated at the national level, while most of the work will be carried out at the community level. Following are the functions that need to be performed and the most logical setting for each function. While designed with a focus on family child care, this vision applies to the entire field of early care and education as well.

The National Level

A major shift in public opinion will be required to mobilize parents and the voting public to support high-quality care, and to make the investment needed to pay for it. This critical need demands no less than leadership from the President and key members of congress.

Federal legislation is needed to finance, coordinate, and guide the delivery of child care services to providers and families. It should also mandate planning and coordination of services supported by various funding streams. Major national mandates are needed in the following functional areas:

1. *Funding to help parents pay for the full cost of quality.* The most critical national need is for supplemental financing — current funding levels must be greatly increased. Two possible approaches to financing make sense:
   - One model is the Army's, where governmental subsidies fill in the difference between affordable fees paid by parents on a full sliding

scale and program expenditures adequate to support quality, including compensation of caregivers based on their education and experience.

- A more expensive but perhaps more politically viable model[26] would be universal child care as a public entitlement, similar to our public schools and some European child care systems.

2. *A comprehensive training system for child care professionals.* From new-provider orientation to advanced college courses that addresses home- and center-based care, training would be appropriate, accessible, and affordable for all caregivers and administrators. A variety of delivery systems for training and supervision in family child care would include systems similar to those now supported by the Army, corporations such as Steelcase, or municipalities such as Madison, Wisconsin (Cohen, 1992; Larner & Chaudry, 1993; Modigliani, 1993a; Morgan et al., 1993; Ward, 1991).

3. *Support for a national professional groups:*

   The National Association for Family Child Care (NAFCC). NAFCC (formerly NAFDC) is a young organization of providers who volunteer their time in addition to typically 60-65-hour work weeks. Their leadership is essential to the professional development of this field.[27] NAFCC should be supported in their efforts to create and support professional associations of family child care, expand their membership, and improve their accreditation system to promote and recognize high-quality care. NAFCC should also develop a strong advocacy voice for providers. Private and/or public funding is needed for at least five years to fund staff positions to accomplish this labor-intensive work. When a substantial membership base is built, the organization should be self-supporting.

   The National Association for Child Care Resource and Referral Agencies (NACCRRA) is a national network of resource and referral agencies that sometime coordinate R&R's delivery of parent services at the community level. These agencies talk to parents at times of critical "teachable moments" for learning about child care; sometimes they also bring together all sectors of child care professionals for community planning and coordination.

   Parent Action / Family Resource Coalition / Parent-Child Centers have the potential to educate parents and mobilize their advocacy.

Other necessary national activities might be funded by other sources — foundations, corporations, state or municipal governments, or some combination of these. Large public-private partnerships, such as the California Child Care Initiative

described above, have been especially successful at accomplishing these kinds of goals, though sustaining funding requires considerable energy. Foundation and corporation funding are ideal for developing and testing innovative new models that, once successful, can then be institutionalized through government funding. Such activities would include:

4. *Ongoing public education.* To build the public will to support our elected officials in the bold approaches described above, we first need to mobilize a national media campaign to help parents and the public at large understand the importance of a child's early learning, the quality of child care, and the value of child care providers. Among the various components, this campaign will depend upon a compelling analysis of the long-term cost-effectiveness and other benefits to individuals and employers. Ongoing public education will be necessary to sustain these gains.

5. *Support for the development of a National Parent/Child Care Professional Alliance.* A national powerful political constituency for quality in child care could be created by a parent-caregiver alliance. Overcoming the currently indifferent or negative relationships between these two groups will require the joint leadership of parents and child care professionals.

6. *Basic research and development.* We must know much more than we do now to support quality early care and education. For two examples, we must define the characteristics of training that improve the quality of care and we must understand more about the effectiveness of different licensing and certification strategies. Funding is also needed to develop appropriate curricula and materials for providers and parents in languages other than English.

The Community Level

Leadership and resource development at the national level will be fruitless unless they are backed up by solid support at the community level. Providers tend to be invisible, isolated, and in need of professional development.

7. *Provider support.* Each community needs a provider association, preferably with a provider resource center (to offer a visible, central location for providers to congregate) to carry out the following:
   a. Training, mentorship, advisement, and licensing support.
   b. Information on topics such as community resources, toy/book/recyclables libraries, and individual problem solving.
   c. Advocacy meetings, model home tours, provider recognition, and other services.

Parent support at the community level is best be carried out by local resource and referral agencies and parent groups coordinated by the national agencies described in functional area 3, above.

8. *Parent Support.* Every community needs the following services:
   a. Referral to several programs that meet parents' basic needs including compatible cultural style.
   b. Ongoing parent counseling including decision support and child care problem solving.
   c. Community referrals to other support services.
   d. Coordinated services (e.g., voucher staff also do child care referral counseling).

These community services would receive guidance and support from the national level, but equally important, they will provide experiential information *to* the national level. Other community supports for high-quality care would include provider-friendly, high-quality early childhood education courses at community and four-year colleges.

Implicit in the call for adequate parent financing and provider services is the recommendation to raise the compensation level of providers, and indirectly their health insurance and retirement savings as well as the quality of environments they offer children. Similarly, the respect for this work must be increased through education of parents and the public at large.

Five years ago, the phrase "child care" was seldom used by the media or even in personal conversations other than those of young mothers. The newfound attention to child care today reflects a new national interest and perhaps a willingness to consider that child care in this country falls far short of its potential. The functions proposed above may seem daunting, although such a major shift in well-being has occurred for our senior citizens within the last few decades, largely through Social Security and Medicare. The next few years will be a critical period of opportunity for significant social change in early care and education. Ideally, President and Mrs. Clinton will lead the way.

ENDNOTES

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[1] The term "family day care" is still used in many states. However, following the professional trend from "day care" to "child care," many provider associations and some states have adopted the term "family child care." The primary purpose for the change is image — "child care" is believed to connote higher quality, while "day care" connotes custodial care. The National Association for Family Child Care recently changed it's name accordingly. Thus, "family child care" is used in this paper.

[2] Susan Kontos' *Family day care: Out of the shadows and into the limelight* summarizes existing research. Ellen Galinsky, Carollee Howes, and Susan Kontos are currently investigating the quality of family child care through the Families and Work Institute in New York. Their study, linked with a study of the Economics of Family Child Care, described in note 16 below, will explore this topic in greater depth than ever before.

[3] Thelma Harms and Deborah Cryer of the Frank Porter Graham Child Development Center are currently attempting to build consensus around the criteria denoting quality in family child care.

[4] Rita Liljestrom (1983), in discussing the meaning of the word "care," quotes Svante Beckman's (1981) analysis of the relation between science and morals, and between knowledge and care. Beckman proceeds from a definition of care that includes nurture and upbringing, looking after and comforting others, accommodating to them, being involved in them. A sense of group belongingness emerges from such caring.

While providers frequently refer to their work in these terms, such qualities are not usually assessed as carefully as more easily measured criteria such as children's access to small motor toys.

[5] The principles of adult education apply especially well to providers, who learn best through experiential activities that have direct relevance to their daily lives. They strongly prefer to create their own meanings, to do things their own way; and they want to learn from each other's experience.

Appropriate training for providers is not overly professionalized. It respects the informality, flexibility, and diversity of family child care. Learning can occur in homey, informal, and easy-going ways, though we have not developed sufficient

curricula to convey this style of teaching. Good trainers help providers learn how to build on their own situations and personal styles.

Some providers are overwhelmed or intimidated by a lot of print. We need more training curricula that do not depend on facile literacy skills. (Dombro & Modigliani, 1993)

[6] The Child Development Associate (CDA) Credential is awarded to providers who have demonstrated competency in 13 functional areas. Most providers require training coursework to prepare for CDA credentialling. (See Modigliani, 1991, for more information.)

[7] The most popular form of accreditation is sponsored by the National Association for Family Child Care (NAFCC). The state of Wisconsin, some municipalities, and some employers have developed their own accreditation instruments, usually more stringent than NAFCC Accreditation. (See Modigliani, 1991, for more information.)

[8] Some states exempt providers who care for fewer than two unrelated children in addition to their own. The logic of this approach was explained by Gwen Morgan (personal conversation, July, 1992) as follows: a provider caring for children from only one family has a special relationship with that family, whereas a provider caring for two or more unrelated children is offering a service to the public. In the former case the parent is the employer; in the latter, the parent is one of the consumers of a commercial service.

[9] Based on my own observations in approximately 200 family child care homes, I propose that states limit group size to six children under age 5 with no more than two children under age 30 months, or three children under age 30 months, with one additional child. Experienced providers would be eligible to add up to two additional school-agers upon license renewal. Large family child care homes should be licensed for twice these numbers of children when a second caregiver is present.

[10] Providers' compliance with regulations seems to vary in response the associated costs and to the style of regulatory staff. Some staff members make a point of working in positive ways with providers, soliciting and responding to their opinions, helping them find ways to come into compliance with the regulations. Others act like police officers, pursuing violators in punitive ways. The former approach is more effective. Providers usually respect regulations when they agree with their purpose and many appreciate that regulation supports them and their peer competitors for doing what is right for children.

[11] Sponsored by the Department of Agriculture to support good nutrition in child care, the CACFP is the largest government support program for providers.

[12] A majority of the 32 Family-to-Family projects have developed family child care mentor programs in the last few years. Their goals may be to help new providers get started and become regulated, to add a practical dimension to training, or to help providers become accredited or obtain their CDAs. Effective mentors are role models, supporters, and coaches. They customize their assistance to match individual providers' interests and learning styles (Dombro & Modigliani, 1993).

[13] Why do some people believe that early childhood teachers in the public schools or good child care centers should have B.A.s or M.A.s, but that family child care providers need no training? This implies that no special knowledge or skill is required to do this job, perhaps that women just naturally know how to do it.

[14] The Family Child Care Project at Wheelock College is conducting a comprehensive study of the Economics of Family Child Care, and the Families and Work Institute is conducting a study of the quality of family child care. These two projects have studied the same providers, and their linked datasets will allow us to describe the relationships among these variables for the first time. Results will be available early in 1994.

[15] On the other hand it should be noted that there are also many providers who make satisfactory or good incomes from family child care. They have access to parents who themselves make decent incomes or live in states that pay a living wage to reimburse care for children from low-income families. Often these providers run large group homes rather than small homes. There are numerous examples of ex-public school teachers and nurses who make higher incomes in family child care than they did in their previous professions. While often the most visible and well known providers, they are the exception.

[16] Providers work for other kinds of compensation beside money: the love of children; the joy of contributing to working families, society, and the well-being of the next generation; and the satisfaction of running their own creative, meaningful business.

[17] Based on an analysis of Census data about workers' education and years of job experience, the National Committee on Pay Equity (1987) found that child care workers across all settings were the second-most underpaid occupation in the United States, controlling for education and years of experience. The most underpaid occupation was the clergy, but this study did not consider fringe benefits, housing and car allowances, and other perks that many clergy receive. If all forms of income were included, child care workers would undoubtedly "win" this unfortunate distinction.

[18] This study is flawed because it assumed that any providers reporting their incomes would also report expenses on Schedule C, which some do not (Modigliani et al., in progress).

[19] There may be a bi-modal distribution with some providers who expect to continue offering care "as long as they are able" and others who will quit in the near future because of insufficient income or because their own children are ready to move on (Modigliani et al., in progress).

[20] The Economics Study will identify and rank other rewards for this work, that providers accept in lieu of income and fringe benefits.

[21] In particular, there is a shortage of infant and toddler care, but providers are not increasing their infant fees to "whatever the market will bear." Hartmann and Pearce attribute the lack of market responsiveness to the situation in which some of the benefits of well raised children accrue to the society, or the public sector, but most of the costs of child care in this society are borne by the private sector, largely by parents. Cost-benefit signals are not properly sent or received, so the market does not undergo the expected adjustments in quality, quantity, and price (1989).

Culkin, Helburn, & Morris (1990b) have clarified and elaborated Hartmann and Pearce's findings. They identify two additional reasons for this market failure. First, high quality child care provides greater benefits than parents realize, so parents spend less on child care than they would if they had full information about its benefits. Second, lower-income families simply cannot afford high quality care. My own interviews with providers in four communities (1993a), Zinsser's ethnographic study of Italian and Irish working-class providers (1990), and Nelson's study of providers in Vermont (1988) suggest that when providers decide how much to charge a parent, they consider the parent's ability to pay as well as how much they themselves want or need to earn. These providers' empathy and altruism creates an information bias which interferes with their response to market forces. Further, providers respond to their job satisfaction as a non-monetary incentive for doing this work (Modigliani, 1993a).

[22] The latest Census statistics report that, on average, working parents spend 6.8% of their income on child care. Women living in poverty spend 21% of their income on child care ("A Realistic," 1992). The Census report is not yet available.

[23] Findings on this subject will be available when the data of the Families and Work study of quality are combined with those from the Economics Study of the same providers' costs and fees.

[24] Employers can also support child care indirectly by becoming more family friendly. Why is it that parents find it easier to tell their supervisors that they were delayed by car trouble than to admit that they had a problem with their child care? Parents,

both fathers and mothers, are seldom encouraged to take time off from work to stay home with children when they are sick or to attend events at their children's child care and schools.

[25] Each of these retailers donates 5% of its taxible income to community projects.

[26] Legislation entitling all children to benefit from a universal child care system might appeal to a greater number of voters, in spite of its increased price tag.

[27] At this time they are trying to build an affiliate or federated membership structure with provider associations in every community, organized into state-wide associations. The professional development fostered by such associations is a key to improving quality.

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